CHI St. Luke's Health
Baylor St. Luke's Medical Center
Imagine better health.

MC 4-262
6720 Bertner Avenue
Houston, TX 77030

P 832.355.1000
CHISt LukesBaylor.org

February 25, 2019

ORIGINAL PLAN OF CORRECTION AND ATTACHMENTS BY OVERNIGHT DELIVERY AND VIA EMAIL

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Dallas Regional Office
Attn: Karen Hillman, Manager – Enforcement Branch
1301 Young Street, Room 827
Dallas, Texas 75202

Texas Health and Human Services Commission
Jennifer Berger, Manager
Jennifer.Berger@hhsc.state.tx.us

Re: **CHI St. Luke's Health Baylor College of Medicine Medical Center ("Baylor St. Luke's Medical Center")**
Reference No. CCN 450193
Intake #TX00303301

Dear Ms. Hillman and Ms. Berger:

I am the President of Baylor St. Luke's Medical Center in Houston, Texas. As you know, from January 7, 2019 to January 11, 2019, the Centers for Medicare & Medicaid Services ("CMS"), in conjunction with the Texas Health and Human Services ("THHSC") surveyed Baylor St. Luke's Medical Center based on complaint intake number 181344022. As a result of alleged deficiencies discovered during that survey, CMS provided a 2567 Statement of Deficiencies alleging noncompliance with certain CMS Hospital Conditions of Participation and removing Baylor St. Luke's Medical Center's "deemed status" as of February 7, 2019.

Though a Plan of Correction ("POC") is not required, Baylor St. Luke's Medical Center is submitting one to demonstrate to CMS and HHSC how seriously Baylor St. Luke's Medical Center is taking this matter. Based on documentation contained in the enclosed Plan of Correction ("POC"), Baylor St. Luke's Medical Center believes that it complies with the cited Hospital Conditions of Participation. Accordingly, Baylor St. Luke's Medical Center requests that you accept the POC as credible evidence of correction and that you reinstate Baylor St. Luke's Medical Center's deemed status.

Baylor St. Luke's Medical Center Corrective Action

Baylor St. Luke's Medical Center has taken swift and decisive actions in order to ensure compliance with Hospital Conditions of Participation and to address the CMS-2567

Statement of Deficiencies (the "2567"). Immediately after the survey and prior to receiving the CMS 2567, Baylor St. Luke's Medical Center took action to begin addressing those concerns expressed by the surveyors in the exit conference. Those efforts included review of and revisions to relevant policies, review of documentation processes in all affected areas of the hospital, internal review of the patient charts discussed with the surveyors, implementation of an audit process, and educational sessions for physicians and staff. As you can see, there are specific dates for each action summarized on the POC, and the latest date for correction of any part of any deficiency is March 6, 2019.

Baylor St. Luke's Medical Center Services to the Community

Baylor St. Luke's Medical Center is licensed for 879 acute beds, including 30 acute inpatient rehabilitation beds. In FY 2018 Baylor St. Luke's Medical Center admitted 23,334 patients, and outpatient visits totaled 115,901, excluding emergency visits. Baylor St. Luke's Medical Center provides full range of services including Anesthesia Service, Cardiac Catheterization Laboratory, Cardiac-Thoracic Surgery, Chemotherapy Services, CT Scanner, Dietetic Service, Emergency Department (Dedicated), ICU - Cardiac (non-surgical), ICU - Medical/Surgical, ICU – Surgical, Laboratory-Clinical, Magnetic Resonance Imagining (MRI), Neurosurgical Services, Nuclear Medicine Services, Occupational Therapy Services, Operating Rooms, Ophthalmic Surgery, Orthopedic Surgery, Outpatient Services, Pharmacy, Physical Therapy Services, Positron Emission Tomography Scan, Post-Operative Recovery Rooms, Radiology Services – Diagnostic, Radiology Services – Therapeutic, Reconstructive Surgery, Respiratory Care Services, Rehab Services – Inpatient, Rehab -Outpatient, Renal Dialysis (Acute Inpatient), Social Services, Speech Pathology Services, Surgical Services – Inpatient, Surgical Services – Outpatient, and Transplant Center (Medicare Certified).

Baylor St. Luke's Medical Center, while not a Trauma Center, has a very busy Emergency Department. In FY 2018, Emergency Department visits totaled 61,455.

Baylor St. Luke's Medical Center and its Medical Staff members and personnel provide numerous resources to the Greater Houston community. Baylor St. Luke's Medical Center is also a significant employer within the community. Baylor St. Luke's Medical Center is also committed to providing care to all patients regardless of economic status. In FY 2018, Baylor St. Luke's Medical Center provided $20.1 million (at cost) in charity care to the community.

During the prior fiscal year, Baylor St. Luke's Medical Center inpatients demonstrated the following payor mix: 49.3% Medicare, 6.8% Medicaid, 0.2% Commercial, 38.4% managed care and 5.2% self pay and other.

As this information demonstrates, Baylor St. Luke's Medical Center's service area relies heavily on the Hospital to provide crucial "safety net" services to individuals who may otherwise go without care as well as a number of valuable services to the community as a whole.

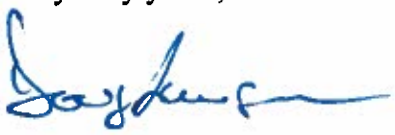
Conclusion

Baylor St. Luke's Medical Center is a valuable and unique asset to the community it serves. Baylor St. Luke's Medical Center provides much needed and readily available patient

care services. Baylor St. Luke's Medical Center believes that it is in compliance at this time with CMS Hospital Conditions of Participation and has taken prompt and comprehensive actions to ensure that it remains in compliance. Based on the actions described above, along with the detailed responses described in the POC, Baylor St. Luke's Medical Center respectfully requests that CMS reinstate Baylor St. Luke's Medical Center's deemed status.

If you have any questions or require additional supporting documentation with regard to Baylor St. Luke's Medical Center compliance with applicable Hospital Conditions of Participation or any other related matter, please do not hesitate to contact me. You may also contact Megan Fischer, Vice President of Quality at mfischer3@stlukeshealth.org or 832-355-8996.

Very truly yours,



T. Douglas Lawson, PhD
President

cc: Mr. Dodjie Guioa, CMS
Ms. Megan Fischer, Baylor St. Luke's Medical Center

Enclosed: Plan of Correction

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450193	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI ST LUKE'S HEALTH BAYLOR COLLEGE OF MEDICINE ME	6720 BERTNER HOUSTON, TX 77030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	A 000		

The Centers for Medicare and Medicaid Services in conjunction with the State of Texas Department of Health and Human Services conducted a complaint survey at CHI ST. Luke's Health Baylor College of Medicine Medical Center. The survey dates were from January 7, 2019 to January 11, 2019.

The hospital census on January 7, 2019 was 543.

This report contains the deficiencies related to the complaint intake number 181344022.

The following Hospital Condition of Participation were deemed out of compliance:

42 CFR 482.21 Quality Assessment & Performance Improvement

42 CFR 482.23 Nursing Service

42 CFR 482.13 Patient Rights

Abbreviations:

ACMO Acting Chief Medical Officer
BP Blood Pressure
CCU Coronary Care Unit
CEO Chief Executive Officer
CNO Chief Nurse Officer
CT Computed Tomography scan
DIC Disseminated Intravascular Coagulopathy
ED Emergency Department
EGD Esophagogastro-duodenoscopy
EMR Electronic Medical Record
EVS Environmental Service

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	2/11/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoP)
Provider Plan of Correction

Provider Name	CHI St Luke's Health Baylor College of Medicine Medical Center	Provider Identification #	450193	Date of Survey	1/11/2019
Address	6720 Bertner Avenue Houston, TX 77030	Complaint Intake #	TX00303301 TX181344022	Survey Type	CMS

Tag A 000 - Through a collaborative effort of Baylor St. Luke's Medical Center's (BSLMC or "Hospital") Senior Leadership, administration, the laboratory, nursing staff, the medical staff and the Governing Body, BSLMC has taken prompt and significant corrective actions to ensure compliance with the CoPs (Conditions of Participation) under Tags A115, A263, A385. BSLMC has corrected all cited deficiencies and has taken steps for sustained compliance with the CoPs over time to ensure safe, quality care for patients. Accordingly, BSLMC respectfully requests that CMS (Centers for Medicare and Medicaid) accept this Plan of Correction (PoC) as credible evidence of current and long-term sustained compliance with the CoPs.

BSLMC is currently in compliance with the CMS Condition of Participation A115 as evidence by the following specific corrective actions, education and monitoring for compliance.

CoP Tag #	Corrective Actions	Education	Monitoring Compliance	Person Responsible Completion Date
A115	• Nursing Leadership reviewed policy expectations regarding the requirement for a physician order prior to drawing blood and adherence to the patient identifier verification process. This was conveyed with staff involved in the event and managed through the Human Resources corrective action process. • ED Leadership clarified to the nursing staff the only acceptable practice for specimen collection is in response to a physician order and the use of the patient identifier verification process. • The Transfusion of Blood Products-Patient Care Policy was revised to include: revisions to the blood transfusion reaction criteria and the	• The Transfusion Services Staff were educated by a member of the Transfusion Services Leadership on the revised policy to reinforce the following: a. Transfusion Services will not accept any specimens which contain more than one label. b. ABO Rh must be confirmed on two separate specimens. • The Transfusion Services staff education reinforced the following pre-existing policy statements: o Transfusion Services will not accept blood specimens that are not properly labeled with the electronic record's specimen label or the label from an electronic down time process. o Report all mislabeled specimens in accordance with the hospital's policy for	An Executive Quality Council (EQC), chaired by the President or Senior Leader designee will meet weekly to provide oversight of the compliance with the monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for 3 months. • Through direct observation, a member of the Transfusion Service Leadership Team audits 20 randomly selected Transfusion Services blood specimens per week with a monthly aggregate of 80 to validate the process of correctly rejecting mislabeled specimens and misidentification (wrong blood in	**Responsible Person:** Chief Nursing Officer **Completion Date:** 3/5/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: President

DATE: 2/26/19

	requirement for ABO Rh on two separate specimens be confirmed before the Transfusion Services will issue non-group O blood. • The Specimen Identification, Collection Labeling and Transportation - Pathology policy was revised to delineate the use of the patient identifier verification process and the required process for labeling specimens at the bedside. • The Specimen Identification, Collection Labeling and Transportation - Pathology policy was revised to clarify the process for rejecting specimens that do not have electronic record's specimen label required for processing. This includes rejection of double labels, misidentification (wrong blood in tube) and defines the unacceptable labeling practices that will require the specimen to be rejected. • In the event of specimen rejection, the Transfusion Services Team Member notifies the departmental leader for follow up as to the reason for deviation from following policy. Appropriate action may include: re-education, training and/or following the Human Resources corrective action process. • The Environmental Services (EVS) standard work plan was modified to include the process for notification to ED staff if bodily fluids are left in the room of a discharged patient. EVS will not begin the cleaning process of any room until all bodily fluids and specimens are removed from the	specimen labeling. Transfusion Services Staff presently on FMLA or LOA will complete the education prior to returning to work. • Nursing Leadership conducted educational training for nursing staff that took place across all shifts and is reinforced by regular nursing leadership rounding to assess competencies. Training has taken place for permanent full time and part time nurses and contract nurses. Education reflected the hospital policies and included:: o Specimens can only be drawn with an order and not left in a patient room. o Drawing specimens and labeling containers using the patient identifier verification process. o Documentation of vital signs, Temperature, Heart Rate, Respiratory Rate, SpO2, Blood Pressure and use of supplemental oxygen prior to, during, and after blood administration. o Frequency of vital sign monitoring during blood administration. o Monitoring of patients receiving blood transfusions, including the replacement of the EMR alert. o Identification of possible signs and symptoms of blood transfusion reactions, processes to stop the transfusion and immediate notification to the Transfusion Services. o Reporting quality and safety concerns. Nursing staff on FMLA or LOA will complete the training prior returning to work. • Specimen labeling, blood administration, and blood transfusion reactions are included in	tube) in accordance with the policy. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Through direct observation, a member of the EVS Leadership team audits 10 rooms cleaned by EVS staff members per week with a monthly aggregate of 40 to validate the new process regarding EVS not cleaning a room until all specimens are removed is in place. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Through direct observation, a member of the ED Leadership team audits 10 instances of specimen collection by ED staff members per week with a monthly aggregate of 40 to validate the specimen collection policy is followed. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Fifty (50) blood transfusion administration records are audited per week with a monthly aggregate	

	room by ED staff. • A retrospective audit of 500 charts was conducted to evaluate current compliance with the Transfusion of Blood Products-Patient Care Policy and the identification of possible blood transfusion reactions.	nursing new staff orientation and incorporated into the competency assessment of blood transfusions. • EVS Leadership conducted educational training for EVS staff that took place across all shifts and is reinforced by regular EVS leadership rounding to assess all bodily fluids have been removed from the room by the ED Staff before beginning to clean a room. EVS staff presently on FMLA or LOA will complete the training prior to returning to work. • Residents were notified of the policy changes for the nursing and laboratory teams. They were provided education related to blood transfusion reactions through one or more of these methods online module, discussion at medical staff meetings, and grand rounds. • Credentialed Providers were notified of the policy changes for the nursing and laboratory teams. They were provided education related to blood transfusion reactions through one or more of these methods in-person training, and discussion at medical staff meetings.	of 200 by nursing leadership for administration of blood in accordance with hospital policy. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Fifty (50) blood transfusion administration records are audited per week with a monthly aggregate of 200 by nursing leadership for identification of a blood transfusion reaction in accordance with hospital policy. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • All reported possible blood transfusion reactions are reviewed and analyzed by a Pathologist daily. Results are aggregated monthly by the Transfusion Services and reported to the Transfusion Committee. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees. Individual deficiencies will be reported to the appropriate supervisor or manager. Any deficiencies will be	

			addressed with the individual through training, re-education and/or following the human resources corrective action process. When 100% compliance is sustained for 3 months the monitoring will continue on an ongoing basis quarterly. If compliance is not sustained quarterly monitoring will go back to weekly with data aggregated monthly for sustained compliance for at least 3 consecutive months. Decisions will be made in accordance with national clinical standards and regulations.	

BSLMC is currently in compliance with the CMS Condition of Participation A263 as evidence by the following specific corrective actions, education and monitoring for compliance.

CoP Tag #	Corrective Actions	Education	Monitoring Compliance	Person Responsible Completion Date
A263	• The hospital's Transfusion Committee Charter has been updated to include Senior Leadership and identifies measures the committee monitors. This Committee is responsible to monitor blood transfusion administration and blood transfusion reactions for compliance with the policy. This Committee is responsible for the analysis of trends and quality improvements of the blood transfusion process. The Committee has been incorporated into the Hospital's Quality Improvement Program by reporting to the Hospital's Quality of Care Committee. • A new position was created, Nurse Practitioner for Patient Blood Management, to improve blood transfusion safety. This position collaborates with the Manager of	• The Performance Excellence Team trained the Hospital Management Team on the tiered huddle approach which was then implemented at the unit/department level. • Education was developed and distributed to reinforce the expectation to identify and report safety and quality concerns in multiple venues to include in person training, new employee orientation, discussion in hospital committee meetings, and leadership rounding. • The revised Quality Assurance and Performance improvement plan was calendared for review and approval on Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees. • Nursing staff and phlebotomists participated in training that took place across all shifts and is reinforced by regular leadership rounding to assess competencies. Training has taken place	• An Executive Quality Council (EQC), chaired by the President or Senior Leader designee will meet weekly to provide oversight of the compliance with the monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for 3 months. • Safety and quality concerns are analyzed and corrective actions developed. The findings are reported quarterly to the Quality of Care Committee, Medical Executive Committee and to the Quality Committee of the Board of Trustees. • The meeting minutes of the Quality of Care Committee, Medical Executive Committee and the Board of Trustees show approval of the	**Responsible Person:** Vice President of Quality **Completion Date:** 3/6/2019

	Transfusion Services and the Technical Supervisor. A nurse practitioner was retained in December 2018 for this position. • The hospital's Quality Improvement Program implemented individual department tiered huddle approach which feeds patient safety and quality concerns from each department up to the Senior Leadership Team. Action items are developed in real time with the implementation tracked by designated individuals on the Senior Leadership Team. • A weekly Executive Quality Council (EQC) has been created to provide oversight and ongoing monitoring of corrective action plans as well as compliance with the monitoring measures for sustained compliance. • The Quality Improvement Program was evaluated and revised to reflect an integrated program for the scope and complexity of services, department specific indicators and the effectiveness of preventive and corrective actions are measured and monitored until sustained improvement is demonstrated. • The Quality Improvement Program reporting calendar was revised to include monthly reports of regulatory findings, completion of action plans, and compliance with monitoring mechanisms. • The Quality Improvement Program distinct improvement project list was	for permanent full time and part time nurses and contract nurses. Topics included: • Cleaning bar code label printers for correct use. • Reporting broken bar code label printers.	QAPI plan, compliance with monthly reports of regulatory findings, completion of action plans, and compliance with monitoring mechanisms. • All work order tickets submitted to IT for bar code label printers are monitored through the tiered huddle approach.	

	updated to include blood transfusion administration and documentation, blood transfusion reactions, specimen collection and labeling. • The current Director of Quality position has been expanded to Vice President of Quality. This position is a member of the Senior Leadership Team and is responsible for oversight and implementation of the QAPI program. The position was hired into on 1/14/2019. • Bar code label printer functionality verification was completed and identified printers not working were repaired or replaced. Further identified printer issues are incorporated in the Hospital's tiered huddle approach.			

BSLMC is currently in compliance with the CMS Condition of Participation A385 as evidence by the following specific corrective actions, education and monitoring for compliance.

CoP Tag #	Corrective Actions	Education	Monitoring Compliance	Person Responsible Completion Date
A385	• Nursing Leadership reviewed policy expectations regarding the requirement for a physician order prior to drawing blood and adherence to the patient identifier verification process. This was conveyed with staff involved in the event and managed through the Human Resources corrective action process. • ED Leadership clarified to the nursing staff the only acceptable practice for specimen collection is in response to a physician order and the use of the	• Education on specimen labeling and rejection of improperly labeled specimens was added to new employee orientation for all Transfusion Services Staff. • Nursing Leadership conducted educational training for nursing staff that took place across all shifts and is reinforced by regular nursing leadership rounding to assess competencies. Training has taken place for permanent full time and part time nurses and contract nurses. Education reflected the hospital policies and included: o Specimens can only be drawn with an order	An Executive Quality Council (EQC), chaired by the President or Senior Leader designee will meet weekly to provide oversight of the compliance with the monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for 3 months. • Through direct observation, a member of the Transfusion Service Leadership Team audits 20 randomly selected Transfusion Services blood	**Responsible Person:** Chief Nursing Officer **Completion Date:** 3/5/2019

	patient identifier verification process. • The Specimen Identification, Collection Labeling and Transportation - Pathology policy was revised to delineate the use of the patient identifier verification process and the required process for labeling specimens at the bedside. • The Specimen Identification, Collection Labeling and Transportation - Pathology policy was revised to clarify the process for rejecting specimens that do not have electronic record's specimen label required for processing. This includes rejection of double labels, misidentification (wrong blood in tube) and defines the unacceptable labeling practices that will require the specimen to be rejected. • In the event of specimen rejection, the Transfusion Services Team Member notifies the departmental leader for follow up as to the reason for deviation from following policy. Appropriate action may include: re-education, training and/or following the Human Resources corrective action process. • The Transfusion of Blood Products-Patient Care Policy was revised to include: revisions to the blood transfusion reaction criteria and the requirement for ABO Rh on two separate specimens are confirmed before the Transfusion Services will issue non-group O blood.	and not left in a patient room. o Drawing specimens and labeling containers using patient identifier process. o Documentation of vital signs, Temperature, Heart Rate, Respiratory Rate, SpO2, Blood Pressure and use of supplemental oxygen prior to, during, and after blood administration. o Frequency of vital sign monitoring during blood administration. o Monitoring of patients receiving blood transfusions. o Transportation of blood products. o Identification of possible signs and symptoms of blood transfusion reactions, processes to stop the transfusion and immediate notification to the Transfusion Services. o "Accept and Complete" reminder to complete the transfusion administration documentation in the EMR. o Monitoring of patients receiving blood transfusions, including the replacement of the EMR alert. o Reporting quality and safety concerns. Nursing staff on FMLA or LOA will complete the training prior returning to work. • Specimen labeling, blood administration, and blood transfusion reactions are included in nursing new staff orientation and incorporated into the competency assessment of blood transfusions. • EVS Leadership conducted educational training for EVS staff that took place across all shifts and is reinforced by regular EVS leadership rounding to assess all bodily fluids have been removed	specimens per week with a monthly aggregate of 80 to validate the process of correctly rejecting mislabeled specimens and misidentification (wrong blood in tube) in accordance with the policy. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Through direct observation, a member of the EVS Leadership team audits 10 rooms cleaned by EVS staff members per week with a monthly aggregate of 40 to validate the new process regarding EVS not cleaning a room until all specimens are removed is in place. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Ten (10) blood product release records from Transfusion Services are audited weekly with a monthly aggregate of 40 by Transfusions Services Leadership for documentation of training prior to release of the blood product and from point of issue to start time of the blood. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the	

	• The delivery of each blood product to the patient's nurse will be accompanied by complete instructions relative to accepting and completing transfusion administration documentation in the EMR. • Transfusion Services reinforced the practice expectations for blood to be released upon verification of training for the transportation of blood product. • Effective 2/25/2019, the hospital replaced the EMR alert for possible blood transfusion reactions with a list of all signs and symptoms of a blood transfusion reaction in accordance with the Transfusion of Blood Products-Patient Care Policy. • The EVS standard work plan was modified to include the process for notification to ED staff if bodily fluids are left in the room of a discharged patient. EVS will not begin the cleaning process of any room until all bodily fluids and specimens are removed from the room by ED staff. • A retrospective audit of 500 charts was conducted to evaluate current compliance with the Transfusion of Blood Products-Patient Care Policy and the identification of possible blood transfusion reactions.	from the room by the ED Staff before beginning to clean a room. EVS staff presently on FMLA or LOA will complete the training prior to returning to work.	Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Fifty (50) blood transfusion administration records are audited per week with a monthly aggregate of 200 by nursing leadership for administration of blood (including vital signs and completion of the transfusion documentation) in accordance with hospital policy. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Fifty (50) blood transfusion administration records are audited per week with a monthly aggregate of 200 by nursing leadership for identification of a blood transfusion reaction in accordance with hospital policy. The findings are reported monthly to the Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees until 100% is sustained for 3 months. • Through direct observation, a member of the ED Leadership team audits 10 instances of specimen collection by ED staff members per week with a monthly aggregate of 40 to validate the specimen collection policy is followed. The findings are reported monthly to the	

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